REGISTRATION FORM

Please copy as needed

Course Title(s)_____

_____

Starting Date(s)_____

If State agency is paying:
I am an authorized agent to expend Department funds.

_____

Signature authorizing billing **RISAIL account#**

_____

Print Name **Date**

Check Enclosed $_____
(If licensed psychologist needing CE credit, see Social Service/Counseling section)

Payment or authorization MUST be enclosed with this registration. Make check payable to **Community Development Training** and mail to: **Office of Training and Development**, RI Department of Administration, One Capitol Hill, Providence, RI 02908-5867

Print name_____

Soc. Sec. No._____

Agency_____

Address_____

_____

Day phone_____ E-mail_____

In the event you must cancel registration, refund will be given **ONLY IF** cancellation is received **NO LATER THAN SEVEN (7) WORK DAYS PRIOR TO THE COURSE STARING DATE**.

Please mail **or** fax – do not do both
If accommodations are needed, please call 2 weeks before the course start date.